Dear Applicant:

Thank you for choosing to become a Montana Medicaid Provider. For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. All sections of the provider enrollment form must be completed in order for us to process your application. **Incomplete applications will be returned.** This application has been designed to comply with federal program requirements. We cannot accept alterations to the provider agreement text on pages 4 and 5.

You will be notified in writing of the status of your enrollment request within fifteen (15) working days of receipt at our office. Please do not bill Montana Medicaid for any services until you have received, in writing, notice of your provider number and its effective date. Claims submitted prior to completion of provider enrollment will be denied.

If you have any questions regarding information required on the enrollment application, please contact ACS Provider Relations at 1-800-624-3958 (in-state only) or 406-442-1837 (out-of-state and Helena).

All Providers

___ 1. Complete and sign the enclosed application.

If the application is for an individual, the individual who will be providing the service must sign it.

If the application is for a facility, an individual authorized to enter the facility into a legal contract must sign it.

___ 2. Complete Question 21 unless you are a Public Health Clinic or a facility with a non-profit tax status (indicate non-profit for Question 7 and on your W-9). An incomplete response to Question 21 will result in the enrollment form being returned.

If the enrolling facility is a non-profit organization or if no individual in the facility has controlling interest of five percent (5%) or more, please enter the information of the person who is the managing officer of the facility as a contact person.

___ 3. Enclose a **photocopy of your current license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also enclose a photocopy of your license covering that date of service. You may also be required to enclose a photocopy of your Medicare Certification Notice. Retroactive enrollment is not guaranteed.

___ 4. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number.

___ 5. On page 2, No. 10, please indicate the date that you want your provider number to be effective.

____6. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Direct Deposit Sign-Up Form (Standard Form 1199A). Failure to return this form will result in the entire provider enrollment package being returned to the provider. **Providers enrolling for new provider numbers cannot choose options 3 or 4 on this form.**

____7. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Electronic Remittance Advice and Payment Cycle Enrollment Form. Failure to return this form will result in the entire provider enrollment package being returned to the provider.

Laboratory Services

___ If you bill laboratory services, you must enclose a copy of your CLIA certification.

Pharmacy

___ If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's NABP number, you must indicate an effective date after the termination date for the previous provider.